Arnold Schwarzenegger, Governor
State of California
Business, Transportation and Housing Agency

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IN REPLY REFER TO
FILE NO: 933 0008
USPS Priority Mail

April 19, 2004

FINAL REPORT

Johnny D. Griggs, Chair, Board of Directors
WATTSHEALTH FOUNDATION, INC.
3405 West Imperial Highway
Inglewood, CA 90303

ROUTINE EXAMINATION OF WATTSHEALTH FOUNDATION, INC.

Dear Mr. Griggs:

Enclosed is the Final Report of a routine examination of the fiscal and administrative affairs of WATTSHealth Foundation, Inc. (the "Plan") for the quarter ended June 30, 2003, conducted by the Department of Managed Health Care (the "Department") pursuant to Section 1382 of the Knox-Keene Health Care Service Plan Act of 1975 ("Act").[1] The Department issued a Preliminary Report to the Plan on February 6, 2004. The Department accepted the Plan's response electronically on March 23, 2004.

This Final Report includes a description of the compliance efforts included in the Plan's March 23, 2004 response, in accordance with Section 1382 (c).

Section 1382 (d) states "If requested in writing by the plan, the director shall append the plan's response to the final report issued pursuant to subdivision (c). The plan may modify its response or statement at any time and provide modified copies to the department for public distribution not later than 10 days from the date of notification from the department that the final report will be made available to the public. The addendum to the response or statement shall also be made available to the public."

Please indicate within ten (10) days whether the Plan requests the Department to append its response to the Final Report. If so, please indicate which portions of the Plan's response shall be appended, and provide copies (hardcopy and electronically) of those portions of the Plan's

[1] References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, California Health and Safety Code Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Division 1 of Chapter 1, Title 28, and California Code of Regulations, beginning with Section 1300.43.

response exclusive of information held confidential pursuant to Section 1382 (c), no later than ten (10) days from the date of the Plan's receipt of this letter.

If the Plan requests the Department to append a brief statement summarizing the Plan's response to the report or wishes to modify any information provided to the Department in its March 23, 2004 response, please provide the documentation (hardcopy and electronically) no later than ten (10) days from the date of the Plan's receipt of this letter.

As noted in the attached Final Report, the Plan's response of March 23, 2004 did not fully resolve some of the deficiencies raised in the Preliminary Report issued by the Department on February 6, 2003. Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for any request for additional corrective action contained in the attached revised Final Report, within thirty (30) days after receipt of the report.

Please send a hardcopy of your response directly to the undersigned. In addition, please file the Plan's response electronically, just as you do for regular licensing filings via the Department's web portal (<https://wp.dmhc.ca.gov/efile>) under **Report/Other**, subfolder RUXAM and barcode RX004. Do not file an Execution Page or Exhibit E-1 (Summary of Filing). Please note this process is separate from the electronic financial reporting and is specifically for the response to this final report only. Questions or problems related to the electronic transmission of the response should be directed to Angie Rodriguez at (916) 324-9048 or email at arodriguez@dmhc.ca.gov or Ed Cheever at (916) 324-8738 or email at echeever@dmhc.ca.gov. You may also email inquiries to helpfile@dmhc.ca.gov.

The Department will make the attached Final Report available to the public in ten (10) days from the Plan's receipt of this letter

If there are any questions regarding this report, please contact me.

Sincerely,

JANET NOZAKI
Supervising Examiner
Office of Health Plan Oversight
Division of Financial Oversight

cc: Alma Graham, Vice President and General Counsel, WATTS Health Foundation, Inc.
Mark Wright, Chief, Division of Financial Oversight
Debra Denton, Assistant Chief Counsel, Office of Enforcement
Thomas Roedl, Examiner, Division of Financial Oversight
Steve Goby, Senior Counsel, Division of Licensing
Gil Riojas, Examiner, Division of Financial Oversight
Evie Correa, Chief Audit Section - Department of Health Services

DEPARTMENT OF MANAGED HEALTH CARE

REPORT OF ROUTINE EXAMINATION

WATTSHEALTH FOUNDATION, INC

FILE NUMBER: 933 0008

DATE OF FINAL REPORT: APRIL 19, 2004

SUPERVISING EXAMINER: JANET NOZAKI

EXAMINER-IN-CHARGE: THOMAS ROEDL

FINANCIAL EXAMINERS:

TINA BUELL
GALAL GADO
MARIA MARQUEZ

BACKGROUND INFORMATION FOR
WATTSHEALTH FOUNDATION, INC.

Date Plan Licensed:	January 30, 1978
Organizational Structure:	The Plan is a not-for-profit corporation exempt from federal and state taxation. The Department took possession of the business and property of the Plan on August 6, 2001 because the Plan was not in compliance with the financial requirements of Section 1376 and Rule 1300.76. The Superior Court of the State of California appointed a Conservator to assume responsibility for the operation of the Plan on October 13, 2001. The Court approved the termination of the conservatorship on October 23, 2003. The Plan's non-compliance occurred from December 31, 2000 to October 31, 2003.
Type of Plan:	The Plan is a full-service health care service plan. The majority of the Plan's revenue consists of premium revenues, principally from contracts with the Local Initiative Health Authority of Los Angeles County and the U.S. Department of Health and Human Services for Medi-Cal and Medicare beneficiaries, respectively. The Plan provides managed health care services for individuals, families, and commercial groups, and for eligible Medicare, Medi-Cal, Healthy Families, and Mothers and Infants enrollees. The Plan also does business under the name UHP Healthcare.
Provider Network:	The Plan arranges for the provision of health care services through capitation and discounted fee for service arrangements with providers.
Plan Enrollment:	94,745 as of November 30, 2003
Service Area:	Southern California
Date of Last Public Report of a Non-Routine Examination:	August 7, 2001

FINAL REPORT OF A ROUTINE EXAMINATION OF WATTSHEALTH FOUNDATION, INC.

This is the Final Report of a routine examination of the fiscal and administrative affairs of WattsHealth Foundation, Inc. (the "Plan") for the quarter ended June 30, 2003 conducted by the Department of Managed Health Care (the "Department"), pursuant to Section 1382 of the Knox-Keene Health Care Plan Act of 1975.[1] The Department issued a Preliminary Report to the Plan on February 6, 2004. The Department accepted the Plan's response electronically on March 23, 2004.

This Final Report includes a description of the compliance efforts included in the Plan's March 23, 2004 response to the Preliminary Report, in accordance with Section 1382 (c).

We performed a limited examination of the financial report filed with the Department for the quarter ended June 30, 2003, as well as other selected accounting records and controls related to the Plan's various fiscal and administrative transactions. We also performed a follow-up examination of the Plan's reorganization as of November 30, 2003 that resulted in the Plan's tangible net equity deficiency being cured.

Our findings are presented in the accompanying attachment as follows:

Section I.	Financial Report
Section II.	Calculation of Tangible Net Equity
Section III.	Administrative Capacity
Section IV.	Compliance Issues
Section V.	Non-Routine Examination

Pursuant to Rule 1300.82, the Plan is required to submit a response to the Department for any requests for additional corrective action contain in this report, within thirty (30) days of receipt of this report.

[1] References throughout this report to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, California Health and Safety Code Section 1340, et seq. References to "Rule" are to the regulations promulgated pursuant to the Knox-Keene Health Care Service Plan Act, found at Title 28, Division 1, Chapter 1, California Code of Regulations, beginning with Section 1300.43.

SECTION I. FINANCIAL REPORT

A. BALANCE SHEET – AS OF NOVEMBER 30, 2003

	Reported per F/S @ 11/30/03	Examination Adjustments Debit	Examination Adjustments Credit	Examination Balance @ 11/30/03
CURRENT ASSETS				
Cash	$ 6,634,000			$ 6,634,000
Short – Term Investment	43,295,000			43,295,000
Premiums Receivables – Net	6,790,000			6,790,000
Interest Receivable	5,000			5,000
Other Health Care Receivable - Net	176,000			176,000
Prepaid Expenses	1,489,000			1,489,000
Unsecured Affiliate Receivables - Current				
Aggregate Write-Ins for Current Assets	5,170,000			5,170,000
TOTAL CURRENT ASSETS	$63,559,000			$63,559,000
OTHER ASSETS				
Restricted Assets	600,000			600,000
Aggregate Write-Ins for Other Assets	470,000			470,000
TOTAL OTHER ASSETS	$ 1,070,000			$ 1,070,000
PROPERTY AND EQUIPMENT				
Land, Building and Improvements	$ 1,735,000			$ 1,735,000
Furniture and Equipment – Net	1,128,000			1,128,000
Computer Equipment - Net	321,000			321,000
Software Development Costs	2,337,000			2,337,000
TOTAL PROPERTY AND EQUIPMENT	$ 5,521,000			$ 5,521,000
TOTAL ASSETS	$70,150,000			$70,150,000

BALANCE SHEET
AS OF NOVEMBER 30, 2003

	Reported per F/S @ 11/30/03	Examination Adjustments Debit	Examination Adjustments Credit	Examination Balance @ 11/30/03
CURRENT LIABILITIES				
Trade Accounts Payable	$ 4,795,000			$ 4,795,000
Capitation Payable	2,849,000			2,849,000
Claims Payable (Reported)	7,026,000			7,026,000
Incurred But Not Reported Claims	26,466,000			26,466,000
Other Medical Liability	10,402,000			10,402,000
Unearned Premiums	566,000			566,000
Loans and Notes Payable	15,000			15,000
Aggregate Write-Ins - Current Liabilities	5,529,000			5,529,000
TOTAL CURRENT LIABILITIES	$57,648,000			$57,648,000
OTHER LIABILITIES				
Loans and Notes Payable (Not Subordinated)	$ 2,164,000			$ 2,164,000
TOTAL OTHER LIABILITIES	$ 2,164,000			$ 2,164,000
TOTAL LIABILITIES	$59,812,000			$59,812,000
NET WORTH				
Retained Earnings (Deficit)	$10,338,000			$10,338,000
Aggregate Write-Ins for Other Net Worth Items	615,000			615,000
TOTAL NET WORTH	$10,338,000			$10,338,000
TOTAL LIABILITIES & NET WORTH	$70,150,000			$70,150,000

B. INCOME STATEMENT

STATEMENT OF INCOME AND EXPENSES
FOR THE QUARTER ENDING NOVEMBER 30, 2003

	Reported per F/S @ 11/30/03	Examination Adjustments Debit	Examination Adjustments Credit	Examination Balance @ 11/30/03
REVENUES				
Premium (Commercial)	$ 990,000			$ 990,000
Capitation	241,000			241,000
Title XVIII – Medicare	10,049,000			10,049,000
Title XIX – Medicaid	6,737,000			6,737,000
Fee-For-Service				
Interest	46,000			46,000
Aggregate Write-Ins for Other Revenue	149,000			149,000
TOTAL REVENUE	$18,212,000			$18,212,000
MEDICAL AND HOSPITAL EXPENSES				
Inpatient Services – Capitated	$ 579,000			$ 579,000
Inpatient Services – Per Diem	5,587,000			5,587,000
Primary Professional Services – Capitated	3,799,000			3,799,000
Other Medical Professional Services – Capitated	2,231,000			2,231,000
Other Medical Professional Services – Non-Capitated	1,368,000			1,368,000
Pharmacy Expense – Fee-for-Service	1,800,000			1,800,000
Aggregate Write-Ins for Other Medical and Hospital Expenses	601,000			601,000
TOTAL MEDICAL & HOSPITAL	$15,965,000			$15,965,000
ADMINISTRATION				
Compensation	$ 654,000			$ 654,000
Interest Expense	8,000			8,000
Occupancy, Depreciation and Amortization	246,000			246,000
Management Fees	150,000			150,000
Marketing	84,000			84,000
Aggregate Write-Ins for Other Expenses	1,021,000			1,021,000
TOTAL ADMINISTRATION	$ 2,163,000			$ 2,163,000
TOTAL EXPENSES	$ 18,128,000			$ 18,128,000
INCOME (LOSS)	$ 84,000			$ 84,000
Extraordinary item	$16,716,000			$16,716,000
NET INCOME (LOSS)	$16,800,000			$16,800,000

SECTION II. CALCULATION OF TANGIBLE NET EQUITY (TNE)

Net Worth Per Examination as of June 30, 2003	$ <8,716,000>
Tangible Net Equity	$ <8,716,000>
REQUIRED TNE as of June 30, 2003	8,682,000
TNE Deficiency as of June 30, 2003	$<17,398,000>

The Plan was not in compliance with the TNE requirements of Section 1376 and Rule 1300.76 from December 31, 2000 to October 31, 2003. As a result of the Plan's non-compliance with the financial requirements of the Act and Rules, the Department took possession of the property and business of the Plan and appointed Franklin Stevens as conservator on August 6, 2001.

On October 23, 2003, by Order of the Superior Court of the State of California, the plan of reorganization proposed by the Plan's conservator and the termination of the conservatorship was approved. As part of the reorganization plan, $29,811,000 in "accrued medical claims subject to compromise" was transferred to a "Creditor Trust". The transfer of cash, property and liabilities from the Plan resulted in the TNE deficiency being cured as of November 30, 2003.

Net Worth Per Financial Report as on November 30, 2003	$ 10,338,000
REQUIRED TNE as of November 30, 2003	8,662,000
Excess TNE as of November 30, 2003	$ 1,676,000

The Plan was required to state the policies implemented to ensure continued compliance with the TNE requirements, the management position responsible for compliance, and the controls implemented for monitoring continued compliance.

The Plan's response included a Tangible Net Equity Compliance Policy. To ensure compliance, the Plan states that it will prepare and submit an annual budget to the Board of Directors for approval. The annual budget will include financial statements and analysis to ensure fiscal soundness and compliance with the TNE requirements.

On a monthly basis, the Plan responded that it will provide to the Board of Directors a Financial Report that includes:

- *Income Statement;*
- *Balance Sheet;*
- *Statement of Cash Flows;*
- *Calculations of Tangible Net Equity; and*
- *Budget-to-Actual Analysis, including an explanation of any variances.*

If at any time the Plan's actual TNE falls below 110% of the required TNE, the Plan responded that

the Chief Financial Officer is responsible for preparing a corrective action plan within 30 days (including financial projections and the timeframe for compliance) for review and approval by the Board of Directors.

To ensure ongoing compliance with the TNE requirements, the Plan states that it's outside auditors will annually review the calculation of TNE and report their findings directly to the Board of Directors. This policy was implemented March 1, 2004. The Plan identified the VP-Chief Financial Officer as the management position responsible for ensuring compliance.

The Department finds that the compliance efforts by the Plan are responsive to the deficiency cited and the corrective actions required.

Section III. ADMINISTRATIVE CAPACITY

Section 1367 (g) and Rule 1300.67.3 require every plan to have the organizational and administrative capacity to provide services to subscribers and enrollees. This includes sufficient staffing in administrative services and written procedures for effective controls that result in the effective conduct of the plan's business.

In order to demonstrate adequate administrative capacity, a plan must have an executive staff and key management staff, which are properly dedicated to performing the necessary functions of a health care service plan. While a plan may enter administrative service agreements with an affiliate or another company to purchase nondiscretionary, ministerial services, Plan management must perform the functions requiring the exercise of any judgment or decision-making. In addition, the responsibility for the day-to-day functions and the oversight of any delegated functions must reside with Plan management.

Our examination disclosed the following deficiencies in administrative capacity:

- The Plan's President - Chief Executive Officer ("CEO") and Executive Vice President - Chief Operating Officer ("COO") positions were vacated.

- The Plan's Claims Department has not been forwarding critical financial information to the Accounting Department. For example, the recovery amounts recorded by Meridian Health Care Management, Inc. ("Meridian"), the Plan's claims processing contractor, were not reconciled to the general ledger. Meridian forwards the recovery amounts to the Claims Department. The Claims Department did not forward the information to the Accounting Department. This should be done on a routine basis in a timely manner.

- The Plan's Claims Department is still reimbursing a high percentage of claims beyond the requirements of Sections 1371 and 1371.35 as discussed in Section IV, A, of this report.

- The Plan's Claims Department did not detect the systemic problems noted in the payment of interest on late claims by Meridian as discussed in Section IV, B, of this report.

- The Plan is still not calculating incurred but unreported claims liabilities on a monthly basis using a method held unobjectionable to the Director as discussed in Section IV, F, of this report.

- The Plan is still not using an adequate method for determining the dollar amount of claims received but not yet paid (claims payable) as discussed in Section IV, G, of this report.

The Department was extremely concerned with the recent vacancies of two key management positions at the Plan. In addition, the Department was concerned that deficiencies noted in prior routine and non-routine examinations have not been corrected. Furthermore, the Department was concerned that the Plan's various departments are not communicating effectively and are not sharing essential information in a timely manner.

The Plan was required to describe, in detail, the corrective action taken by management to ensure that the Plan's fiscal and administrative services are efficiently managed in compliance with Section 1367(g) and Rule 1300.67.3. Such corrective action was to include a detailed description of all controls and procedures implemented by Plan management to address the concerns noted above. The Plan's response was to include an explanation of who will handle the duties and responsibilities of the CEO and COO and a timetable of when these key positions will be filled. The Plan was also required to review its operations and establish policies that will assure the effective and timely communication between the Plan's various departments. In addition, the Plan was required to demonstrate that adequate oversight, authority, and responsibility have been retained by the Plan for all delegated functions.

Furthermore, the Plan was required to indicate the date corrective actions were implemented, the management position responsible for ensuring the corrective actions taken, and the controls implemented for ongoing monitoring to assure continued compliance.

The Plan provided the following response:

1. CEO/COO Vacancies

The Plan responded that it recognizes the important roles that the CEO and COO play in ensuring compliance with Section 1367(g) and Rule 1300.67.3. The Plan reported that Mr. Curtis Owens has assumed the role of UHP's President/Chief Executive Officer as of March 22, 2004 to ensure that fiscal and administrative services are efficiently managed. To assist the new CEO, Ron Bolding, an eighteen (18) year veteran Plan employee, has been appointed by the Board as Acting Chief Operating Officer. The Plan identified the Board of Directors as the party responsible for ensuring the corrective actions taken. These actions have an implementation/completion date of May 22, 2004.

2. Adequate Management

The Plan responded that current staffing includes strategic and appropriate lead positions for the core fiscal and administrative operations. These include key department management positions in Claims, Finance, Member Services, Provider Network Services and Quality and Utilization Management. All of these core positions are manned by experienced staff that meet bi-weekly

during HMO management operations committee meetings. These positions are managed by area Vice President positions for Managed Healthcare Services, Finance, Business Operations, and Outcomes Management. The tenure of the Vice Presidents range from 2 to 18 years. To address the vacancy of the Chief Operating Officer (COO) position, existing staff have taken on additional responsibilities to ensure that plan functions continue to be performed as required. The Plan identified the Board of Directors as the party responsible for ensuring the corrective actions taken.

3. Facilitating Communication

The Plan responded that it recognizes the importance of effective communication among departments, between line staff and management, and between the Plan and the entities performing services on its behalf. To facilitate effective ongoing communication among these stakeholders, the Plan states that it has instituted several regular meetings, described below:

- ***Weekly Operations Meeting***

  Since implementation of the outsourcing of claims processing in August 2002, representatives of Plan's Claims department have met with representatives of the Claims Processing Organization (CPO) on a periodic basis. The Plan submitted a Weekly Operations Meeting Policy to the Department that formalized this meeting. To ensure effective information transfer from the Claims department to the Accounting department; the Plan states that the Controller, or designee, will also participate in the meeting. Financial Affairs will use information obtained during these meetings to ensure accurate and timely financial reporting of claims activity to the general ledger. Accounting's policies and procedures, including but not limited to, Overpayments, Refunds and Interest/Fee calculations have been revised and were submitted to the Department to reflect this process.

  The Plan states that the CPO will maintain a record of attendees and meeting notes to ensure that decisions made are communicated to all appropriate parties. The CPO also will monitor the status of open issues, ongoing discussions, and closed issues.

- ***Business Management Team Meeting***

  The Plan responded that it recognizes that timely inter-department communication is very important for effective management and performance of the Plan's responsibilities. To facilitate ongoing communication among the Plan's major departments and functional areas, the Plan's Business Management Team (BMT) meets on a weekly basis. At this meeting, each functional leader provides a report of current activities. Although the BMT has been meeting regularly, the Plan formalized the meeting in its Business Management Team Meeting Policy that was submitted to the Department. To ensure that a record of meeting topics and decisions is kept, the Plan states that the Project Manager will prepare meeting agendas, a list of attendees and action items log complete with Staff Responsible and Due Date.

- ***Quarterly Joint Operations Meeting***

  Senior Management from the Plan and the CPO will meet on a quarterly basis to discuss operational performance. This meeting is formalized in the Weekly Joint Operations Meeting Policy submitted to the Department. The Plan identified the Acting VP – Chief Operating Officer as the position responsible for ensuring the corrective actions taken. This practice was implemented March 1, 2004.

4. Oversight of Claims Processing Organization

The Plan responded that it recognizes the importance of maintaining oversight of its CPO. The Plan acknowledges that it is ultimately responsible for compliance with all appropriate regulations, even though certain functions may be delegated to other parties. To formalize this responsibility, the Plan implemented the Oversight of Claims Processing Organization Policy that it submitted to the Department. The policy identifies the Vice President, Managed Healthcare Services as the management position responsible for monitoring the CPO's activities, reviewing performance reports, and auditing CPO transactions. At least one day per week, the Plan's Director of Claims will work on site at the CPO to provide regular oversight and assistance with activities related to the CPO's work on the Plan's behalf. The Plan identified the VP – Managed Healthcare Services as the management position responsible for ensuring the corrective actions implemented on March 1, 2004.

5. Ensuring Compliance

The Plan responded that it has in place an extensive Quality Control Process to verify that its CPO is performing in compliance with the Plan's prescribed policies and statutory requirements. As described in the Policy that was submitted to the Department, the Plan will audit CPO performance on a daily and monthly basis.

Also the Plan responded that it reserves the right to audit the CPO's performance with regard to any contractual or regulatory requirement. The results of daily audits are forwarded to the CPO for explanation and correction, if necessary. The results of monthly audits are reported in formal Audit Findings for review by senior management and the Plan's Board of Directors. The Plan believes that regular audits are the most effective technique for identifying deficiencies, verifying the correction of these deficiencies, and ensuring compliance going forward. The Plan identified the VP – Managed Healthcare Services as the management position responsible for ensuring the corrective actions implemented on March 1, 2004.

6. Untimely Payment/Denial of Claim

The Plan's response to this deficiency is presented under Section IV, Sub-section A-Claims Reimbursements.

7. Incorrect Interest/Penalty Calculation

The Plan's response to this deficiency is presented under Section IV, Sub-section B-Payment of Interest.

8. Unacceptable Calculation of IBNR Claims

The Plan's response to this deficiency is presented under Section IV, Sub-section F-Incurred But Not Reported.

9. Inadequate Calculation of IBNP Claims

The Plan's response to this deficiency is presented under Section IV, Sub-section G-Claims Payable.

The Department finds that the compliance efforts by the Plan are not fully responsive to the corrective actions required in the following respect:

- **The Plan's response did not include a timetable of when the Chief Operating Officer (COO) position would be permanently filled. It also did not specify the additional responsibilities assigned to existing staff to ensure that Plan functions continue to be performed while the COO position is vacant.**

- **The Plan's response did not include oversight procedures to ensure that the CPO will maintain a record of attendees and meeting notes for the weekly meetings to ensure that decisions made are communicated to all appropriate parties. The Plan's response also did not include its oversight procedures to ensure that the CPO is monitoring the status of open issues, ongoing discussions, and closed issues.**

The Plan is required to submit the information noted above in its response to this final report.

SECTION IV. COMPLIANCE ISSUES

A. CLAIMS REIMBURSEMENT – Repeat Deficiency

Sections 1371 and 1371.35 require a health care service plan to reimburse claims no later than 45 working days after receipt of the claim, unless the claim is contested or denied by the plan in which case, the claimant shall be notified in writing, that the claim is contested or denied, within 45 working days after receipt by the health care service plan.

A sample of claims was selected for review during the examination. The number and type of claims reviewed is summarized below.

CLAIM TYPE	NUMBER OF CLAIMS REVIEWED
Paid	237
Denied	46
Pended	20

Based on our review, 71 claims out of the 257 paid and pended claims reviewed were paid beyond the 45 working day requirement, representing 28% of our claim sample of paid and pended claims. This includes 15 claims that were underpaid and the subsequent payment to correct the underpayment was paid more than 45 working days after the claim was received. A sample of claims not paid within 45 business days is shown below:

CLAIM NO.	DATE RECEIVED	DATE PAID	DAYS LATE
02010312008	12/11/02	3/6/03	20
010310261167	10/24/02	1/24/03	27
010240216011	10/18/02	2/14/03	54
12240260316	12/11/02	5/8/03	78
10310260205	9/23/02	2/3/03	68
010210260526	9/25/02	1/10/03	38

In addition, a significant amount of the denied claims reviewed during the examination were not denied in a timely manner. Of the 46 denied claims reviewed, 11 (or 24%) were denied after 45 days.

A sample of claims not denied within 45 days after they were received is as follows:

CLAIM NO.	DATE RECEIVED	DATE DENIED	DAYS LATE
175323	12/08/00	11/29/01	181
10090260562	09/30/02	02/28/03	104
10010260221	09/24/02	11/05/02	29
269605	11/15/00	01/30/03	553

This is a **repeat deficiency** since violations of Section 1371 and 1371.35 were noted in the prior two routine examinations and in the non-routine examination performed on November 20, 2000, as well as follow-up procedures performed in January 2001 and in April 2001. Furthermore, the Plan violated the undertaking filed with the Department in May 2000 that the Plan would comply with Section 1371 at all times.

The Plan was required to provide a detailed description of the policies and procedures implemented to ensure that all claims are paid or denied within the timeframe required by Section 1371 and 1371.35. The Plan's response was to state the date these policies and procedures were implemented, and the management position responsible for ensuring ongoing compliance with Section 1371 and Section 1371.35.

These repeat claim violations were referred to the Office of Enforcement due to the Plan's failure to correct this problem.

The Plan responded that its existing Claim Processing and Control Standards Policy supports the claims processing timeliness standards of Section 1371 and Section 1371.35. As required by the regulations, all claims are be paid or denied within 45 working days of the regulatory receipt date.

The Plan also responded that it has instituted several additional procedures as described below:

1. *Daily and Monthly Review of Claim Aging Reports*

The Plan submitted its Claim Processing and Control Standards Policy with its response. This policy states that the Plan will consistently pay claims in a timely manner and will produce daily and monthly reports showing the age of claims by product type. The Director of Claims, or designee, will review these daily reports and work with the CPO to expedite any claims nearing overdue statues. The Plan identified the VP – Managed Healthcare Services as the management position responsible for ensuring the corrective action taken. This policy was implemented on February 1, 2004.

2. On-Site Assistance with Overdue Claims

The Plan submitted its Oversight of Claims Processing Organization Policy with its response. This policy states that the Director of Claims will work on-site at the CPO at least one day per week. During this time, the Director will assist with processing of any claims approaching overdue statues by providing training, answering questions, and/or referring claims to the Plan's Claims Department for follow-up. The Plan identified the VP – Managed Healthcare Services as the management position responsible for ensuring the corrective action taken. This policy was implemented on March 1, 2004.

3. Claims Processing Audits

The Plan submitted its Quality Control Process Policy and Weekly Operations Meeting with its response. This policy states that the Plan will perform daily and monthly audits of claims processing activities performed by the CPO. These audits include validation that claims processing meets the timeliness standards described in the Claim Processing and Control Standards Policy. If untimely claims are identified through daily audits, the Plan will issue the CPO a written citation and request explanation and correction of the error. An agenda item for claim timeliness is added to the weekly Operations meeting so that the corrective action can be monitored. In the case of negative findings identified in the monthly audits, the CPO is required to submit a corrective action plan to the Plan within one week of receiving the citation. The Plan identified the VP – Managed Healthcare Services as the management position responsible for ensuring the corrective action taken. This policy was implemented on March 1, 2004.

In its response, the Plan respectfully requests that this deficiency be deleted from the DMHC's final report.

The Plan's request to delete this deficiency was denied because it did not explain how the Conservator prevented the Plan's management from overseeing the CPO.

A copy of Plan's response has been forwarded to the Office of Enforcement.

B. PAYMENT OF INTEREST – Repeat Deficiency

Section 1371 further states that if an uncontested claim is not reimbursed within the 45 working day period, interest shall accrue at the rate of fifteen percent (15%) per annum beginning with the first calendar day following the 45 working day period. A plan failing to comply with this requirement shall pay the claimant a $10 fee for all claims, including those for emergency services.

Section 1371.35 (b), which refers to claims resulting from emergency services, requires that if an uncontested claim is not reimbursed within 45 working days after receipt, the plan shall pay the greater of $15.00 or interest at the rate of 15% per annum, beginning with the first calendar day after the 45 working day period.

Our examination noted that no interest and/or penalties were paid, or were incorrectly paid, for 53 claims that were paid after 45 working days, representing 21% of paid and pended claims. Furthermore, interest was not paid on these claims, or was paid after the examination commenced and the deficiency had been brought to the Plan's attention.

A sample of late paid claims in which interest or penalties still have not been paid is shown below:

CLAIM NO.	DATE RECEIVED	DATE PAID	DAYS LATE	INTEREST & PENALTY DUE
01210313101	11/20/02	3/4/03	34	$686.64
01310312009	12/23/02	3/4/03	5	$79.35
09210211801	9/6/02	11/15/02	5	$15.34
02040313601	11/22/02	2/14/03	19	$25.23
0269367	1/24/03	6/5/03	67	$68.48

A sample of claims where interest was underpaid is shown below:

CLAIM NO.	DMHC INTEREST & PENALTY	INTEREST & PENALTY PAID BY PLAN	UNDERPAID
1110261235	$168.36	$114.43	$53.93
03240360079	$18.65	$16.29	$2.36
010250260719	$86.44	$76.58	$9.86

A sample of claims where interest was overpaid is shown below:

CLAIM NO.	DMHC INTEREST & PENALTY	INTEREST & PENALTY PAID BY PLAN	OVERPAID
0613021817	$27.37	$105.74	$78.37
01030360445	$304.81	$719.27	$414.46
091270212401	$322.94	515.27	$192.33
02120360188	$191.60	$200.74	$9.14

The first three claims in the table above are those claims in which the Plan paid interest on the entire payment amount when interest was due only on the additional payment that was paid after 45 working days.

This is a **repeat deficiency** since violations of Section 1371 and 1371.35 were noted in the two prior routine examinations and the non-routine examination performed on November 20, 2000, as well as, follow-up procedures performed in January 2001 and in April 2001. Furthermore, the Plan violated the undertaking filed with the Department in May 2000 that the Plan would comply with Section 1371 at all times.

This matter was brought to the attention of Plan management to investigate since it appeared that Meridian had a systemic problem with paying interest correctly on late claims and the Claims Department had not detected this problem.

The Plan was required to submit a Corrective Action Plan ("CAP") that provides for the identification of all claims since August 8, 2002 on which interest should have been paid. The CAP was to include any claims that were first denied in error and later paid.

Furthermore, the Plan was required to submit evidence that the correct amount of interest and $10 fee, if applicable, were paid for all claims identified. If this process is not completed at the time the Plan files its response, the CAP was to state the timeframe in which the identification and payments will be completed. The Plan was reminded that the interest rate on late claims was ten (10%) percent up to December 31, 2000. Effective January 1, 2001, Section 1371 was amended to increase the interest rate on late claims to fifteen (15%) percent.

The CAP was to include the policies and procedures implemented to ensure that late claims payments will include the correct interest and penalties. The CAP was also to state the date the policies and procedures were implemented, the management position responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure ongoing compliance with the corrective action.

These repeat claim violations were referred to the Office of Enforcement.

The Plan acknowledges that its CPO was not correctly calculating interest and penalty payments due for claims processed more than 30 working days after receipt. The Plan cited the CPO on multiple occasions for non-compliance with Claim Processing and Control Standards Policy.

To correct this deficiency, the CPO has reprocessed all claim payments processed after August 1, 2002. As a result of this reprocessing, the Plan identified 4,093 claims with interest and penalty errors. The Plan responded that as of March 12, 2004 all of these claims have been paid correctly. An Interest Recalculation Listing Report was submitted with the Plan's response as evidence that claims with interest and penalty errors have been paid correctly.

The Plan responded that it has taken the following actions to ensure future compliance with Section 1371 and Section 1371.35(b):

1. Policy for Payment of Interest and Penalties

The Plan submitted an Interest/Penalty Payments Policy. The policy states that the Plan is to pay interest and penalties in compliance with Section 1371 and Section 1371.35 (b). The Plan identified the VP – Managed Healthcare Services as the management position responsible for ensuring the corrective action taken. This policy was implemented on March 1, 2004.

2. Report of Interest/Penalties

The Claim Processing and Control Standards Policy states that the CPO will produce a monthly report of interest paid for clean, regular, and emergency claims. The Director of Claims will review this report to ensure that interest and penalties are being paid in compliance with Section 1371 and Section 1371.35 (b). The Plan identified the VP – Managed Healthcare Services as the management position responsible for ensuring the corrective action taken. This policy was implemented on February 1, 2004.

3. Claims Processing Audits

The Quality Control Process Policy states that the Plan will perform daily and monthly audits of all claims processing activities. These audits verify compliance with the interest/penalty calculations and payment. The results of daily audits are communicated to the CPO for explanation and correction. In the case of monthly audits, formal audit reports will be prepared for review by senior management and the CPO. The CPO must submit a corrective action plan in response to any negative findings of the monthly audits within one week of the receipt of the audit findings. The Plan identified the VP – Managed Healthcare Services as the management position responsible for ensuring the corrective action taken. This policy was implemented on March 1, 2004.

In its response, the Plan respectfully requests that this deficiency be deleted from the DMHC's final report.

The Plan's request to delete this deficiency was denied because it did not explain how the Conservator prevented the Plan's management from overseeing the CPO.

A copy of Plan's response has been forwarded to the Office of Enforcement.

C. ACCURACY OF CLAIM PAYMENTS

Our examination noted that some claims were not being paid the correct amount indicating that the Plan is not properly overseeing the pricing being performed by Meridian.

A sample of claims that were overpaid and underpaid is shown below:

CLAIM NO.	DMHC REPRICING	AMOUNT PAID	OVERPAID <UNDERPAID>
05020312803	$23.77	$73.50	$49.73
11260260011	$284.75	$387.25	$102.50
01210211403	$425.00	$597.72	$172.72
01020360371	$0	$1,700.84	$1,700.84
011140211628	$1600.00	$2,718.00	$1,118.00
05150311153	$3,425.00	$9,718.00	$6,293.00
010100260148	$975.00	$10,289.25	$9,314.25
12170260669	$22,075.47	$26,214.61	$4,139.14
04050313137	$4,787.41	$12,619.93	$7,832.52
04100360749	$29,690.50	$35,188.75	$5,498.25
0409360545	$34,191.71	$39,786.72	$5,595.01
01210211701	$54,442.08	$59,176.17	$4,734.09
06130321817	$1,778.24	$1,454.92	<$323.32>
09280260138	$460.00	$300.00	<$160.00>
012040213114	$7,620.54	$7,495.94	<$124.60>
*03180360186			<$1,650.00>
*01270311802			<$2,699.00>

* The Plan made a subsequent payment after the provider appealed. The provider sent a refund check for the original amount paid resulting in the underpayment.

The Plan was required to submit policies and procedures implemented to ensure that claims payments are calculated and paid correctly. The Plan was also to state the date the policies and procedures were implemented, the management position responsible for overseeing the corrective action, and a description of the monitoring system implemented to ensure ongoing compliance with the corrective action.

The Plan acknowledges that a few claims were not paid correctly. The Claims Processing Policy states that all claims will be paid in accordance with the applicable regulatory statutes. However, because the claims processing function is performed on behalf of the Plan by an external claims processing organization, the Plan's ability to ensure compliance with this

regulation is mostly retrospective. To ensure that claims are calculated and paid correctly, the Plan responded that it has implemented the following policies:

1. Communication of Business Rules

The Plan responded that CPO is dependent on the Plan to provide information that it is integral to accurate calculation and payment of claims. The Weekly Operations Meeting services as the primary opportunity for communication of policy and procedure information to the CPO, such as benefit and coverage changes; provider contract revisions; and other business-rule related changes. The Plan directives requiring implementation are recorded in the meeting notes, and implementation is tracked and reported by the CPO. The Plan will verify correct implementation via the audits described below. The Plan identified the VP – Managed Healthcare Services as the management position responsible for ensuring the corrective action taken. This policy was implemented on March 1, 2004.

2. Oversight of Claims Processing Organization

The Oversight of Claims Processing Organization Policy states that the Vice President, Managed Healthcare Services is responsible for monitoring all CPO performance, to include weekly meetings with CPO management, review of CPO performance reports, and daily/monthly audits of CPO activities. At least one day per week, the Director of Claims, or designee, will work on site at the CPO to provide regular oversight of, and assistance with, activities related to the CPO's performance on behalf of the Plan. The Plan identified the VP – Managed Healthcare Services as the management position responsible for ensuring the corrective action taken. This policy was implemented on March 1, 2004.

3. Claims Processing Audits

The Quality Control Process Policy states that the Plan will perform daily and monthly audits of all claims processing activities. These audits verify compliance with the claims payment accuracy standards, and correct implementation of business rules directives presented at the Weekly Operations Meeting. The results of daily audits are communicated to the CPO for explanation and correction. In the case of monthly audits, formal audit reports are prepared for review by senior management and the CPO. The CPO must submit a corrective action plan in response to any negative findings of the monthly audits within one week of the receipt of the audit findings. The Plan identified the VP – Managed Healthcare Services as the management position responsible for ensuring the corrective action taken. This policy was implemented on March 1, 2004.

The Department finds that the compliance efforts by the Plan are responsive to the deficiency cited and the corrective actions required.

D. STATUS OF CLAIMS

Rule 1300.77.4 requires all plans to institute procedures whereby all claims received by the plan are maintained and accounted for in a manner which permits the determination of date of receipt

of any claim, the status of any claim, the dollar amount of unpaid claims at any time and the rapid retrieval of any claim.

Our examination disclosed that the Plan has failed to implement procedures that comply with Rule 1300.77.4 in that numerous claims cannot be located. The claims that could not be located are generally those that were processed by the Plan, rather than those claims processed by the Plan's contracted claims processor, Meridian.

Furthermore, the Plan has violated the Undertaking filed with the Department in May 2000 that provided assurances that it would maintain all books and records for a minimum of five (5) years in accordance with Rule 1300.85.1.

Examples of internally processed claims that could not be located include the following claims:

CLAIM NO.
500152
200280
500152
200280
500152
200280

The Plan was required to state the policy and procedures implemented to resolve the above deficiency, the date of implementation, the management position responsible for compliance, and the controls implemented for monitoring continued compliance.

This violation was referred to the Office of Enforcement.

The Plan acknowledges that a few claims requested by the DMHC could not be located. These claims were from the period prior to the outsourcing of claims to a CPO. All claims requested after the outsourcing of claims were located. The Plan's CPO has in place comprehensive claim inventory procedures, described in the following policies that were submitted with the response:

- *MHCM ACS Mailroom Claims Process Flow Policy &Procedure*
- *Sorting, Batching and Scanning of Claims Policy &Procedure*

The MHCM Imaging and Process Flow Schematic submitted with the response graphically depicts the claims entry and imaging workflow. These policies support the maintenance and retrieval of all claims, including attachments. As such, the location and retrieval of claims has not been an issue since August 1, 2001.

The Plan responded that it audits the CPO's adherence to these policies via the daily and monthly audits described in the Quality Control Process Policy. While on-site at the CPO, the Director of Claims monitors for uncontrolled claims by observation.

The Plan identified the VP – Managed Healthcare Services as the position responsible for ensuring the corrective action taken. These policies were implemented on March 1, 2004.

In its response, the Plan respectfully requests that this deficiency be deleted from the DMHC's final report.

The Plan's request to delete this deficiency was denied because the missing claims were ones that were internally processed by the Plan personnel. The Plan's response did not include an explanation as to why the Plan could not locate claims in its possession.

A copy of Plan's response has been forwarded to the Office of Enforcement.

E. PAYMENTS TO NON-CONTRACTED PROVIDERS

Rule 1300.67 describes the basic health care services required to be provided by a health care service plan to its enrollees. Rule 1300.67 (g) states that coverage for emergencies involving enrollees shall be provided on a reimbursement or fee-for-service basis.

Section 1371.4 (c) states that payment for emergency services and care may be denied only if the health care service plan reasonably determines that the emergency services and care were never performed.

Section 1379 states that the subscriber or enrollee shall not be liable to the provider for any sums owned by the Plan.

The Plan's internal policy is to reimburse ER and outpatient services provided by out-of-state providers an arbitrary rate of 20% of billed charges and then to pay additional reimbursement up to 100% of billed charges if the provider appeals. This internal policy was confirmed by an e-mail dated November 26, 2003 for claim number 02120360188 instructing Meridian to pay 20% of billed charges and states "if we owe the provider more let them appeal the claim."

There was no letter of agreement or supporting documentation that the non-contracted provider agreed to this arrangement or that reimbursement rate was comparable to the rate paid to non-contracted provider located in California for the same service. The Plan stated this policy was implemented to assist Meridian in processing claims timely when the Medicaid rate of the out-of-state provider was not available. Denying a portion of the claim may result in the provider making a claim against the enrollee for the balance. However, no instances of balance billing were reviewed during our examination.

The Plan was required to state the policies and procedures implemented to ensure compliance with Rule 1300.67 and Sections 1379 and 1371.4. The Plan was to include the date of implementation, the management position responsible for compliance, and the controls implemented for monitoring continued compliance. In addition, the Plan was to describe its procedures to ensure that enrollees are not balanced billed by non-contracting providers who are not fully paid for services rendered.

The Plan was required to submit a Corrective Action Plan ("CAP") that provides for the identification of all out-of-state claims since August 8, 2002 that were paid an arbitrary rate.

Furthermore, the Plan was required to submit evidence that either the out-of-state provider has agreed to the arbitrary rate or that the arbitrary rate paid is comparable to the Medi-Cal rate paid for the same service provided in California.

The Plan acknowledges the requirements of Rule 1300.67, Section 1379 and Section 1371.4. To ensure compliance with these regulations, the Plan responded that it has implemented the policy revisions described below:

1. Reimbursement of Non-Contracted Providers

The Plan responded that it did not previously have a formalized policy which addressed the reimbursement of ER and outpatient services provided by out-of-state providers however, the practice was to reimburse at 20% of billed charges, an amount which was derived from a claims analysis of non-contracted providers' actual payment rates. This analysis produced a range of Medicaid payment rates from 12% to 20% of billed charges. It was decided that, in the absence of the known out-of-state Medicaid rate, the provider would be reimbursed at 20% of billed charges. Effective March 1, 2004, the Plan has implemented a formal policy and procedure to ensure that the provider's interim reimbursement rate for Medi-Cal or Medicaid patients out of state is properly paid. The Plan submitted a Non-Contracted Provider Payments Policy with its response. The policy states that it is in compliance with rule 1300.67(g) for emergency and outpatient non-contracting rates. The CPO has been trained on the payment for Emergency claims (no authorization required) and the Plan will monitor the CPO's compliance with this policy via daily and monthly audits and payment reviews. The Plan identified the VP – Managed Healthcare Services as the management position responsible for ensuring the corrective action taken. This policy was implemented on March 1, 2004.

2. Balance Billing Provisions

The Plan's Explanation of Payments (EOP) tells the provider that Knox-Keene prohibits billing the member. The Plan responded that it will ensure that this language is revised to explicitly state that the provider is prohibited from balance billing the member. The Plan responded that it will also revise the denial letter that it sends to non-contracted providers to say that the provider is prohibited from balance billing the member. The Plan identified the VP – Managed Healthcare Services as the management position responsible for ensuring the corrective action taken. The Plan states that the implementation of this practice is ongoing.

3. Processing of Emergency Services Claims

The Plan submitted an Emergency/Urgent Care Services Policy with its response. The policy states that the Plan may only deny claims for emergency services if it is determined that the services were never actually rendered. This policy was implemented January 1987 and revised February 2004. The Plan responded that it will verify compliance with this policy via the audits described in its Quality Control Process Policy. The Plan identified the VP – Managed

Healthcare Services as the management position responsible for ensuring the corrective action taken.

4. Corrective Action Plan for Out-of-State Provider Claims

- *The Plan responded that it has identified approximately 650 out-of-state Medi-Cal and Commercial claims processed since August 8, 2002.*
- *For those claims identified, the Plan responded that it will compare the rate paid to the comparable Medi-Cal rate for the same service in California.*
- *In those cases where the provider agreed to accept a specific rate, the Plan will provide evidence of that agreement.*
- *In those cases where the provider was underpaid, the Plan will reimburse the provider at the rate they would have been paid if the services was rendered in California in addition to any and all applicable interested and/or penalty fees.*
- *The following rate table (pre-AB1455) defines the reimbursement methodology the Plan will use to adjust any claim determined to be underpaid.*

	Inpatient	***Outpatient Surgery***	***Outpatient Services***	***Professional Services***	***Emergency Services***	***Ambulance***
Medi-Cal	*Average of Quarterly Interim % Rate*	*Ambulatory Surgical Center Grouper Pricer*	*Medi-Cal Fee Schedule*	*Medi-Cal Fee Schedule*	*Medi-Cal Fee Schedule*	*Medi-Cal Fee Schedule*
Commercial	*100%*	*Ambulatory Surgical Center*	*Ambulatory Payment Classification*	*Medicare Fee Schedule + 15%*	*Ambulatory Payment Classification*	*100% of billed charges*
		Grouper Pricer	*+ 15%*		*+ 15%*	

The Plan identified the VP – Managed Healthcare Services as the management position responsible for ensuring the corrective action taken. The Plan responded that this process will be completed by June 15, 2004.

The Department acknowledges that the Plan's corrective actions will be completed by June 15, 2004. However, the Plan is required to submit a schedule of the 650 out-of-state claims identified and to state the corrective action taken for each of these claims to the Department by June 30, 2004.

F. INCURRED BUT NOT REPORTED CLAIMS – Repeat Deficiency

Section 1377 (c) that every plan which reimburses providers of health care services on a fee-for-service basis, or which directly reimburses its subscribers or enrollees to an extent exceeding ten percent of its total payments for health care services, shall estimate and record in the books of account a liability for incurred and unreported claims.

Rule 1300.77.2 (a) states that each plan that reimburses providers of health care services on a fee-for service basis shall calculate the estimate of incurred and unreported claims using a method held unobjectionable by the Director. Such method may include a lag study, an actuarial estimate, or other reasonable method of estimating incurred and unreported claims. The amount required by Rule 1300.77.1 to be accrued in the plan's books and records must equal the estimated total of all claims incurred but not yet received as of the end of the month as calculated in working papers, schedules, or reports prepared in support of the unobjectionable lag study, actuarial estimate, or other method or estimating incurred and unreported claims.

Our examination disclosed that the Plan failed to calculate incurred but unreported claims liabilities on a monthly basis using a method held unobjectionable to the Director in the following respect:

- The Plan estimates IBNR by adding one month of IBNR (based on PMPM data that had not been documented by the Plan), and deducting any claims payments for the month, to the previous month's IBNR balance. Although, our analysis indicates that the Plan's IBNR was overstated for the quarter ending June 30, 2003 and for the month ending November 30, 2003, the Plan's method has a high chance for error in estimating IBNR.

- The Plan relies upon a year-end actuarial review of the incurred but unreported claims to determine adequacy.

- The Plan does not perform a hindsight comparison of the amount reported as IBNR to the actual dollar amount paid. A comparison is needed to determine if the Plan's method is reliable, and reasonably reflects an adequate estimate of IBNR.

- The Plan failed to prepare lag studies based on the Plan's various lines of business.

- The Plan failed to routinely obtain the encounter data for Centinela Hospital Medical Center from the Plan's claims processing contractor, Meridian. Centinela Hospital Medical Center receives a monthly advance payment for services provided.

This is a **repeat deficiency** since the Plan's failure to calculate incurred but unreported claims liabilities on a monthly basis using a method held unobjectionable to the Director was noted in the prior non-routine examination.

During this examination, the Plan's management stated that they are currently in the process of hiring a consultant to develop and implement an actuarial model to calculate the incurred but unreported claims of the Plan.

The Plan was required to revise the methodology used to calculate incurred but unreported claims to a method that is unobjectionable to the Director and to provide a detailed description of the method the Plan will use to calculate the liability for these claims. The Plan was required to perform a hindsight analysis of its IBNR reserves (i.e., run-out) on a quarterly basis to determine if the Plan's method is reliable, and reasonably reflects an accurate estimate of IBNR. The Plan was also required to prepare a lag report prepared with paid claim data that has been reconciled with the cash disbursements for the same period. The Plan was required to state the management position responsible for ensuring continued compliance.

Furthermore, the Plan was required to file an executed copy of the consultant agreement electronically as an amendment filing with the Department. The cover page for the filing was to state that it was filed as a result of the recent financial examination. The Plan was requested to provide evidence (i.e., a copy) in its response that the requested filing had been submitted to the Department within forty-five (45) days after receipt of the preliminary report.

The Plan responded that the following actions have been implemented to ensure correct and accurate calculation of incurred but unreported claims liabilities:

1. IBNR Claims Calculation Methodology

The Plan has engaged Milliman USA, Inc. to develop and implement a methodology for calculating Incurred But Not Reported (IBNR) claims. This tool was implemented on February 19, 2004. The Plan submitted the Implementation Letter, a description of the IBNR Tool, and a User's Manual with its response. The Plan identified the VP – Chief Financial Officer as the management position responsible for ensuring the corrective action taken.

2. Hindsight Analysis

The Plan has implemented a quarterly hindsight analysis on its IBNR reserves as described in its IBNR Review Policy submitted with its response. This analysis was implemented on March 1, 2004. The Plan identified the VP – Chief Financial Officer as the management position responsible for ensuring the corrective action taken.

3. Lag Report

The Plan responded that a Lag Report using paid claim data is prepared using the IBNR Tool described above. The report is reconciled with cash disbursements for the same period. This process was implemented on March 1, 2004. The Plan identified the VP – Chief Financial Officer as the management position responsible for ensuring the corrective action taken.

The Plan responded that it has filed an executed copy of the consultant agreement with Milliman USA as an amendment filing with the DMHC dated March 17, 2004. A copy of the letter and proof of filing was submitted with its response.

The Department finds that the compliance efforts by the Plan are responsive to the deficiency cited and the corrective actions required.

G. CLAIMS PAYABLE – Repeat Deficiency

Rule 1300.77.4 requires every plan to institute procedures whereby all claim forms received by the plan from providers of health care services for reimbursement on a fee-for-service basis and from subscribers and enrollees for reimbursement are maintained and accounted for in a manner which permits the determination of the date of receipt of any claim, the status of any claim, the dollar amount of unpaid claims at any time, and rapid retrieval of any claim.

Our examination disclosed that the Plan does not have an adequate method for determining the dollar amount of claims received but not yet paid (claims payable). The Plan records the previous month's claims payments as the claim payable for the subsequent month. The Plan's method is unreliable, and does not reasonably reflect the dollar amount of claims payable.

This is a **repeat deficiency** that was noted in the two prior routine examinations.

The Plan was required to submit the procedures implemented that will result in an accurate reflection of the dollar amount of claims payable in compliance with Rule 1300.77.4. The Plan was required to include the management position responsible for continued compliance and a description of the monitoring system implemented to ensure continued compliance.

The Plan was required to explain why the corrective action, as described in the Plan's May 26, 2000 response was not implemented. In addition, the Plan was required to state the measures taken to prevent further recurrence of noncompliance.

The Plan responded that its previous management made a concerted effort to implement the corrective action plan of May 26, 2000 regarding claims payable. It was later determined that the Plan's existing systems were not capable of producing reports needed to calculate claims payable liabilities. The Plan attempted to implement a series of systems enhancements such that the needed reports could be prepared and the corrective action plan fully implemented. As of August 8, 2001, under the Conservator's direction and under the Department's supervision and approval, the Plan abandoned this implementation effort. This was one factor in the Conservator's decision to engage an outside CPO, which has the systems capacity to produce the needed reports.

The Plan submitted a Claims Payable Policy with its response. The Plan states that it has instituted policies and procedures to estimate the dollar amount of claims received as of any given month end. This process uses a report received daily from the CPO of actual claim counts of claims received but not yet paid, including the billed amount as well as an aging of the claims. This report was used by the Financial Affairs department to fairly estimate the amount of claims payable as required by Rule 1300.77.4. The Plan identified the VP – Chief Financial Officer as the management position responsible for the corrective action taken. The Plan states that it implemented this process with its January 2004 filing.

The Department finds that the compliance efforts by the Plan are responsive to the deficiency cited and the corrective actions required.

H. EXPLANATION OF PAYMENT

Meridian's claims processing system automatically pays one cent if a provider bills using an incorrect modifier and/or an incorrect Medi-Cal service code for a billed item, unless the claims processor manually denies that billed item. If the claims processor does not deny the incorrect service code, the explanation of payment that is attached to the claim check does not clearly state that an incorrect service code was used resulting in one cent ($0.01) being paid for that billed item.

Although the Plan believes that the two claims (06160360132 and 04240360111) identified during the examination were isolated errors made by the claims processors, the Department believes that the explanation of payment needs to be modified to provide a clear explanation to the provider of the amount being reimbursed.

The Plan was required to state the corrective action taken to resolve this deficiency and the management position responsible for monitoring continued compliance.

The Plan responded that the payment of $0.01 for certain claims was the result of an examiner error. In some instances the claims examiner used $0.01 as a placeholder during the claim adjudication process. Use of this placeholder was never a policy of either the Plan or its CPO. Upon discovery of this error, the Plan notified its CPO, which provided additional training to its claims examiners. The Plan will verify the CPO's corrective action and ongoing compliance via the audits described in its Quality Control Process Policy. This action was implemented on March 1, 2004. The Plan identified the VP – Managed Healthcare Services as the management position responsible for ensuring the corrective action taken.

The Department finds that the compliance efforts by the Plan are responsive to the deficiency cited and the corrective actions required.

I. DMHC FINANCIAL REPORTING

The Plan failed to report Medi-Cal dental enrollees enrolled through the County of Los Angeles-Department of Health Services on the DMHC financial report. The enrollees not reported were those who had dental coverage only. There were 6,782 dental-only enrollees as of June 30, 2003. However, the Plan reported the correct amount to the Department as of March 31, 2003 for assessment purposes.

The Plan was required to correct and restate the enrollment reported to the Department in the quarterly filings for 2003.

The Plan was required to state the policies and procedures implemented to correct the above deficiency, the date of implementation, the management position responsible for compliance, and the controls implemented for monitoring continued compliance.

The Plan submitted a DMHC Enrollment Report Policy with its response. The policy was implemented on January 1, 2004 to ensure that monthly, quarterly, and annual reporting of enrollment includes all enrollees, including those for the Medi-Cal Dental contract. The Plan

identified the Controller as the individual responsible for day-to-day compliance with this policy and the Chief Financial Officer will provide oversight by reviewing DMHC filings prior to submission.

UHP has submitted the revised quarterly reports for the four quarters of 2003.

The Department finds that the compliance efforts by the Plan are responsive to the deficiency cited and the corrective actions required.

J. FIDELITY BOND

Sections 1351 (q) and 1376 and Rule 1300.76.3 require each plan to maintain at all times a fidelity bond covering each officer, director, trustee, partner and employee of the plan, whether or not they are compensated. The fidelity bond may be either a primary commercial blanket bond or blanket position bond written by an insurer licensed by the California Insurance Commissioner. Our review of the Plan's fidelity bond disclosed the following deficiencies:

- The Plan's fidelity bond excludes losses from employees in cases in which a director, officer, or partner of the Plan had knowledge of the employees' acts of theft, fraud, or dishonesty.

- The Plan's fidelity bond did not include a provision to provide thirty days notice to the Director prior to cancellation.

The policy expired on August 15, 2003. During the examination, the Plan provided an endorsement to the replacement policy that included the thirty days notice to the Director prior to cancellation.

The Plan was required to electronically file a copy of its fidelity bond that includes an endorsement explaining that the exclusion applies only in cases where the officer, director or partner knew of the acts yet did not report the incident and the acts continue. In addition, the Plan was requested to provide evidence (i.e., a copy) in its response that the requested filing has been made within forty-five (45) days after receipt of this report.

The Plan responded as follows:

On March 18, 2004, the Plan filed an Amendment submitting its current Fidelity Bond that is required by California Code of Regulations, Title 28, Section 1300.76.3. The Department's Transaction ID number evidencing that the Plan filed the Bond is 1079577899812. The Plan, through its insurance broker, requested its insurance carrier to issue an endorsement or "letter of interpretation" mandated by the Department concern exclusion of losses. The Plan advised the Department's Supervising Examiner, Janet Nozaki, that the broker refused to issue either the endorsement or the "letter of interpretation." In lieu of having the Plan obtain a Fidelity Bond from another carrier mid-term, Ms. Nozaki instructed that the Plan in this Response represent as follows: the Plan represents that it will instruct its broker to begin looking for another carrier who is willing to issue, at the end of the term (8/2004) of the Fidelity Bond ("Bond"), a Bond that contains an endorsement or "letter interpretation" explaining that the exclusion of losses where a director, officer or partner of the Plan had knowledge of the employees' acts of theft, fraud or dishonestly applies only in cases where such individual knew of the acts yet did not report the incident and the acts continued. Alternatively, the

Plan represents that it will notify the Department, before the expiration of the current Bond if it is unable to find a carrier to issue a Fidelity Bond with an endorsement or "letter of interpretation" concern losses as requested by the Department. The Plan's response included evidence of it filing with the Department. The Plan identified its VP – Legal as the position responsible for ensuring the corrective action stated above.

The Department acknowledges the representation by the Plan to resolve this deficiency. However, the Plan is required to file with the Department the Fidelity Bond it obtains to replace its current Fidelity Bond upon its expiration.

K. MONITORING FINANCIAL VIABILITY OF CAPITATED PROVIDERS

Rule 1300.67.8(c) requires a health plan to monitor the financial capacity of providers when they are compensated on a capitated basis. Section 1375.1(a)(3) and (b) requires a health plan to demonstrate a procedure for prompt payment or denial of provider claims and the financial soundness of the Plan's arrangements for health care services. Health plans that capitate provider groups and delegate claims payment functions to these provider groups must have procedures in place to ensure that these groups comply with Sections 1371, 1371.35 and 1375.1(a)(3) and (b).

Our examination included a review of the Plan's monitoring program for its capitated providers and capitated hospitals. Our review disclosed that the Plan did not adequately monitor these providers, as discussed below:

- The Plan has not been performing reviews of the capitated providers' calculation for the incurred but not reported claims liability.

- The Plan failed to monitor the financial performance of Watts Health Care Corporation after its incorporation.

- The Plan failed to obtain and review the financial statements of four capitated hospitals.

The Plan was required to state the procedures implemented to ensure that the Plan is receiving and reviewing reports from its capitated providers as necessary to ensure that the providers have sufficient processes in place for compliance with Sections 1371, 1371.35 and 1375.1(a)(3) and (b), as well as, perform on site reviews as necessary. The Plan was required to provide a copy of the updated policies and procedures, state the date implemented, the management position responsible for ensuring continued compliance in this area.

The Plan responded that it recognizes the importance of reviewing capitated providers to ensure ongoing financial viability. The Plan states that it has taken the following steps to resolve this deficiency:

1. Review of IBNR Claims Liabilities for Capitated Medical Groups

The Plan responded that its Internal Audit department (IA) began conducting annual on-site

financial reviews of all capitated medical groups in order to assess financial viability. These reviews include the calculation of IBNR claims liability. On a quarterly basis, IA reviews capitated providers using a desktop review of financial ratios. The Plan submitted its Desk Review Policy and Medical Group – On-site Review Policy with its response.

The Plan responded that IA conducts reviews of approximately 30 capitated medical groups annually. The Plan stated that it has entered into a collaborative agreement with L.A. Care Health Plan to perform audits on behalf of the Plan for the remaining 22 medical groups. This collaborative agreement is intended to ensure that compliance is met with respect to financial solvency while at the same time maximizing oversight of capitated medical providers and minimizing impact to their business operations. This action was implemented in October 2003. The Director of Internal Audit is responsible for overseeing the process. The Plan submitted a copy of this agreement with its response.

2. Financial Monitoring of WHCC

The Plan responded that it obtained partial financial statements for Watts Health Care Corporation (WHCC) for the quarter ended June 30, 2003. The Plan also received complete financial statements for the quarter ended September 30, 2003 and will continue to receive complete statements on an ongoing basis. The Plan's Internal Audit Department will monitor WHCC's financial position on a quarterly and annual basis. This action was implemented on June 30, 2003. The Plan identified the Director of Internal Audit as the individual responsible for overseeing this process.

3. Capitated Hospital Financial Statements

The Plan responded that it has sent letters, dated March 3, 2004, requesting financial statements from its four capitated hospitals in order to complete the financial viability review by the Internal Audit department.

The Plan stated that its policies were modified February 18, 2004 and November 10, 2003, respectively. The Plan identified the Director of Internal Audit as the individual responsible for ensuring compliance with these Policies.

The Department finds that the compliance efforts by the Plan are responsive to the deficiencies cited and the corrective actions required.

SECTION V. NON-ROUTINE EXAMINATION

The Plan is advised that the Department may conduct a non-routine examination, in accordance with Rule 1300.82.1, to verify representations made to the Department by the Plan in response to this report. The cost of such examination will be charged to the Plan in accordance with Section 1382 (b).

No response was required to this Section.